DEPARTMENT OF HEALTH CARE FINANCE

NOTICE OF FINAL RULEMAKING

The Director of the Department of Health Care Finance (DHCF), pursuant to the authority set forth in An Act to enable the District of Columbia to receive federal financial assistance under Title XIX of the Social Security Act for a medical assistance program, and for other purposes, approved December 27, 1967 (81 Stat. 774; D.C. Official Code § 1-307.02 (2016 Repl. & 2019 Supp.)) and the Department of Health Care Finance Establishment Act of 2007, effective February 27, 2008 (D.C. Law 17-109; D.C. Official Code § 7-771.05(6) (2018 Repl.)), hereby gives notice of the adoption of an amendment to Chapter 9 (Medicaid Program) of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR).

This rulemaking adds a new Section 939 (Adult Hospice Services) to Chapter 9 (Medicaid Program) of Title 29 DCMR. The new Section 939 establishes standards for the delivery of and reimbursement for hospice care provided to terminally ill District Medicaid beneficiaries twenty-one (21) years of age and older residing in home settings, in accordance with individualized, written plans of care. This rulemaking describes the scope of the items and services covered under the adult hospice benefit and clarifies the reimbursement methodology for beneficiaries receiving hospice care while residing in a nursing facility or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). DHCF estimates total expenditures for the adult hospice benefit to increase by $10,726,912 in Fiscal Year 2020, as a result of the proposed changes.

These rules correspond to a related State Plan Amendment (SPA), which was approved by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) on March 19, 2020. Accordingly, these rules became effective February 15, 2020, The corresponding SPA was added to the District's Medicaid State Plan, which can be found on DHCF's website at https://dhcf.dc.gov/page/medicaid-state-plan.

A Notice of Emergency and Proposed Rulemaking was published on February 14, 2020 in the *D.C. Register* at 67 DCR 1617. The following comments were received from Legal Counsel for the Elderly (LCE), the Office of the DC Long-Term Care Ombudsman. Based on a review of the comments, no changes have been made.

Support of Beneficiary Choice and Written Agreements

LCE expressed strong support of patient choice in directing both long term services and supports (LTSS) and end-of-life care. LCE stated that these regulations ensure transparency and support beneficiary choice in directing such care, and LCE supported the regulatory language in ensuring hospice is a meaningful and available choice to all D.C. Medicaid beneficiaries with terminal illnesses. LCE further expressed support for the regulatory language ensuring Medicaid beneficiaries receive all services they are entitled to receive even when enrolled in adult hospice care. LCE specifically expressed support for the language in § 939.30 requiring written agreements between hospice providers and nursing facilities or ICF/IDD. LCE explained that such language establishes important procedural requirements for individuals who reside in a facility with a terminal illness and opt for hospice care. LCE explained that one such requirement, also required

by federal regulation, requires the hospice provider and nursing facility to identify their individual responsibilities for patient care. LCE concluded that this requirement ensures that the role of each entity is clear and that the patient is receiving the highest quality of care without gaps in services. Since LCE expressed support and does not recommend changes under the forgoing comments, DHCF is not making any changes.

Timeframe for DHCF Prior Authorization

LCE commented that one area where they seek clarification is in regard to the timeframe for DHCF prior authorization for the reimbursement of hospice care under § 939.25. LCE explained that for both new admissions and each election period, transparency is required. Specifically, LCE worried about a disruption or delay in services due to pending prior authorization. While this section relates to the payment of the hospice providers, LCE expressed concern that care will not be rendered without authorization for payment. LCE recommended that the timeframe for prior authorization to the hospice provider from DHCF be specified and made retroactive to prevent any disruption in services.

DHCF does not believe this level of detail is necessary in the rulemaking. DHCF works closely with providers to promptly issue prior authorizations to minimize barriers and any delays to hospice care. As long as a beneficiary has an order for hospice services and meets medical necessity, DHCF will authorize services. Additionally, DHCF is able to retroactively authorize services, as long as the request was submitted prior to initiation of services. For these reasons, DHCF is not proposing any changes.

The Director adopted these rules on June 10, 2020 and they shall become effective on the date of publication of this notice in the *D.C. Register*.

Chapter 9, MEDICAID PROGRAM, of Title 29 DCMR, PUBLIC WELFARE, is amended as follows:

A new Section 939, ADULT HOSPICE SERVICES, is added to read as follows:

939 ADULT HOSPICE SERVICES

939.1 This rule shall govern the administration of adult hospice services under the District of Columbia (District) Medicaid Program.

939.2 Adult Hospice services shall be furnished by providers operating in accordance with 42 CFR § 418.114 and requirements set forth in the District of Columbia Health Occupations Revision Act of 1985, as amended effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201.01, *et seq.*), and its implementing rules.

939.3 A provider of adult hospice services is a public agency or private organization, or subdivision of either, that is primarily engaged in providing care to terminally ill adult beneficiaries, which may include any of the following entities:

(a) A hospital;

(b) A Hospice enrolled in the Medicare program; or

(c) A nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID).

939.4 To be eligible for District Medicaid reimbursement for adult hospice services, a provider shall meet the following requirements:

(a) Meet the Medicare conditions of participation for hospices, 42 CFR Part 418, Subparts C, D, and F, be enrolled in the Medicare program, and be enrolled as a District Medicaid provider with DHCF; and

(b) Employ or contract with an interdisciplinary team, which shall include at least one (1) of each of the following:

(1) Doctor of medicine or osteopathy;

(2) Registered nurse (RN) or advanced practice registered nurse (APRN);

(3) Licensed clinical social worker (LICSW); and

(4) Pastoral or other counselor.

939.5 All members of the hospice interdisciplinary team shall be able to provide expertise and services twenty-four (24) hours per day, seven (7) days per week.

939.6 To be eligible to receive adult hospice services, a beneficiary shall meet the following criteria:

(a) Is enrolled in District Medicaid;

(b) Is aged twenty-one (21) or older;

(c) Resides in a home setting, or in a nursing facility or ICF/IID;

(d) Is certified as terminally ill in accordance with §§ 939.7 – 939.9; and

(e) Has elected to receive hospice care in accordance with § 939.10.

939.7 A written certification of terminal illness shall be completed no more than fifteen (15) calendar days before the effective date of an election period described at § 939.12, and shall include all of the following:

(a) A statement that the beneficiary has a medical prognosis of life expectancy of six (6) months or less if the terminal illness runs its normal course;

(b) Clinical information and other documentation supporting the medical prognosis, which shall be filed in the medical record with the written certification;

(c) A brief narrative explanation of the clinical findings that support a life expectancy of six (6) months or less, which meets the following requirements:

(1) The narrative shall be located immediately above the physician's signature;

(2) For the initial election period certification and second election period certification described in § 939.12, the narrative shall include a statement attesting that the narrative is based on a review of the beneficiary's medical record;

(3) The narrative shall reflect the beneficiary's individual clinical circumstances and cannot contain check boxes or standard language used for all patients; and

(4) For the third election period certification and each subsequent election period certification described in § 939.12, the narrative shall include a statement attesting that the narrative is based on a face-to-face encounter with the beneficiary described in § 939.9; and

(d) Signatures of the hospice medical director or the physician member of the hospice interdisciplinary team, and the beneficiary's attending physician, specialty care physician, or primary care physician.

939.8 The hospice provider shall obtain a written certification of terminal illness no later than two (2) calendar days after the beginning of each election period.

939.9 Not more than thirty (30) calendar days prior to the completion of the certification statement for the third election period, as described in § 939.13, and each subsequent election period thereafter, a hospice physician or hospice nurse practitioner shall have a face-to-face encounter with any beneficiary whose total time in hospice is anticipated to exceed one hundred eighty (180) calendar days.

939.10 For each period of hospice care elected, the beneficiary or authorized representative shall file with the hospice provider an election statement that includes the following:

(a) Identification of the hospice provider that will care for the beneficiary;

(b) An acknowledgement by the beneficiary or his/her authorized representative that the beneficiary has been given a full explanation of the palliative rather than curative nature of hospice care as it relates to the beneficiary's terminal illness;

(c) An acknowledgement by the beneficiary or his/her authorized representative that the beneficiary fully understands that an election to receive hospice care is a waiver of the Medicaid services described in § 939.16;

(d) The effective date of the election to receive hospice care; and

(e) The signature of the beneficiary or his/her authorized representative.

939.11 Where a beneficiary electing hospice care lacks the mental capacity to make an election, his/her authorized representative shall file the election statement pursuant to the requirements set forth in the Health Care Decisions Act of 1988, effective March 16, 1989 (D.C. Law 7-189; D.C. Official Code §§ 21-2201, *et seq.*).

939.12 Adult hospice services may be provided for limited time frames known as election periods. An election period for hospice care shall consist of one or more of the following:

(a) An initial election period of ninety (90) days;

(b) A second election period of ninety (90) days;

(c) A third election period of sixty (60) days; and

(d) An unlimited number of subsequent election periods of sixty (60) days.

939.13 A beneficiary's election to receive hospice care shall continue through the initial election period and any subsequent election periods without a break in care as long as the beneficiary remains in the care of an enrolled hospice provider, does not revoke the election, and is not discharged from hospice care.

939.14 A beneficiary may change to a different hospice provider no more than once in each election period, subject to the following conditions:

(a) In such circumstances, the beneficiary shall not begin a new election period; and

(b) To ensure continuity of care, both hospice providers shall be required to coordinate the provision of services during the beneficiary's transition.

939.15 A beneficiary may revoke the election of hospice care at any time. To revoke the election of hospice care, the beneficiary or his/her authorized representative shall file with the hospice provider a signed and dated revocation statement subject to the following:

(a) A beneficiary's revocation statement shall include the date on which the revocation of the election of hospice care is to be effective. The effective date may not be earlier than the date that the revocation statement is filed with the hospice provider; and

(b) A beneficiary's revocation of the election of hospice care does not preclude him/her from reelecting hospice care at a later date.

939.16 A beneficiary shall waive all rights to Medicaid coverage for the following services for the duration of the election to receive hospice care:

(a) Hospice care provided by a hospice provider other than the hospice provider designated by the beneficiary, unless provided under arrangements made by the designated hospice; and

(b) Any Medicaid services related to treatment of the terminal condition for which hospice care was elected or a related condition, or services that are equivalent to hospice care, except for those:

(1) Provided by the designated hospice;

(2) Provided by another hospice under arrangements made by the designated hospice; or

(3) Provided by the beneficiary's attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services.

939.17 A beneficiary who elects to receive adult hospice services remains entitled to receive other medically necessary Medicaid-covered services, drugs, or supplies, not included in the adult hospice benefit, that are for a condition unrelated to the terminal illness for which hospice care was elected.

939.18 When a beneficiary enrolled in a home and community-based services (HCBS) waiver authorized under Section 1915(c) of the Social Security Act, including but not limited to the District's Elderly and Persons with Physical Disabilities (EPD) waiver and Individuals with Intellectual and Developmental Disabilities (IDD) waiver, elects to receive adult hospice services, the following conditions apply:

(a) The beneficiary's waiver case manager or service coordinator and hospice provider staff shall meet in advance to develop a coordinated plan of care for the beneficiary, completed within five (5) days of the beneficiary's first day of hospice care, which clearly defines the roles and responsibilities of the HCBS waiver services provider and the hospice provider and avoids duplication of services;

(b) The hospice provider shall provide all medically necessary services that are directly related to the beneficiary's terminal illness; and

(c) The HCBS waiver program may continue to provide services that are:

(1) Unrelated to the beneficiary's terminal illness; and

(2) Assessed by the beneficiary's waiver case manager or service coordinator as necessary to maintain the beneficiary's safe residence in a home- or community-based setting.

939.19 To be covered by Medicaid, adult hospice services shall meet the following requirements:

(a) The services are reasonable and necessary for the palliation and management of the terminal illness and related conditions;

(b) The services are provided to a beneficiary who meets the requirements at § 939.6; and

(c) The services provided are consistent with the written plan of care, which was developed by the interdisciplinary team described in § 939.4 and established prior to the beneficiary's first day of hospice care.

939.20 The following services are covered adult hospice services, when consistent with the plan of care and provided in accordance with recognized standards of practice and any requirements or limitations set forth by federal or District law and the District's State Plan for Medical Assistance:

(a) Physician services performed by a physician as defined in 42 CFR § 410.20, except that the services of the hospice medical director or the physician member of the interdisciplinary group shall be performed by a doctor of medicine or osteopathy;

(b) Nursing services provided by or under the supervision of a registered nurse;

(c) Medical social services provided by a licensed clinical social worker practicing under the direction of a physician;

(d) Counseling services provided to the terminally ill beneficiary and family members or other persons who care for the beneficiary at home, in accordance with the following requirements:

(1) Counseling, including dietary counseling, may be provided both for the purpose of training the beneficiary's family or other caregivers to provide care, and for the purpose of helping the beneficiary and those caring for him/her to adjust to the beneficiary's approaching death; and

(2) Counseling services are not available to nursing facility or ICF/IID personnel who care for a beneficiary receiving hospice care in the facility;

(e) Short-term inpatient hospice care provided in a participating Medicare or Medicaid hospice inpatient unit, hospital, or nursing facility that meets hospice staffing and space requirements described in 42 CFR Part 418, Subparts C and D, in accordance with the following requirements:

(1) Inpatient hospice care may be required for procedures necessary for pain control or acute or chronic symptom management, and may also be furnished as a means of providing respite for the individual's family or other persons caring for the beneficiary at home; and

(2) Respite care shall be furnished as specified in 42 CFR § 418.108(b);

(f) Durable Medical Equipment (DME) and medical supplies for the palliation or management of the beneficiary's terminal illness or related conditions, which shall be provided by the hospice provider for use in the beneficiary's home;

(g) Prescription drugs used primarily for the relief of pain and symptom control related to the beneficiary's terminal illness;

(h) Physical therapy, occupational therapy, and speech-language pathology services provided for symptom control or to enable the beneficiary to maintain activities of daily living and basic functional skills;

(i) Home health aide and homemaker services, in accordance with the following requirements:

(1) Home health aides shall provide personal care services and may also perform household chores necessary to maintain a safe and sanitary environment in areas of the home used by the beneficiary. Home health aides shall deliver services under the general supervision of a registered nurse;

(2) Homemaker services may include assistance in maintenance of a safe and healthy environment and other services that enable the beneficiary, caregiver(s), and hospice provider to carry out the plan of care;

(3) Personal care aide (PCA) services, in accordance with Chapter 50 of Title 29 DCMR and to the extent that the hospice provider would routinely use the beneficiary's family to support implementation of the plan of care. Additional hours of PCA services may be authorized if medically necessary, in accordance with 29 DCMR § 5003; and

(4) The hospice provider shall ensure coordination between home health aide and homemaker services under adult hospice with PCA services provided under the Medicaid State Plan personal care benefit, and shall be responsible for submitting a request for a PCA Service Authorization to DHCF or its designated agent in accordance with 29 DCMR § 5003, and for integrating the plan of care prepared by the PCA provider into the adult hospice plan of care; and

(j) Other services specified in the beneficiary's plan of care as reasonable and necessary for the palliation or management of the terminal illness and related conditions, which are otherwise covered by District Medicaid.

939.21 Core services covered under the adult hospice benefit include the following:

(a) Physician services;

(b) Nursing care;

(c) Medical social services; and

(d) Counseling services.

939.22 All core services listed at § 939.21 shall be routinely provided directly by hospice employees, except that the hospice provider may contract for the provision of core services under the following circumstances:

(a) To obtain physician services;

(b) The hospice provider has entered into a written arrangement, with another hospice provider meeting the criteria set forth in §§ 939.3 through 939.5, for the provision of core services to supplement hospice employees to meet the needs of beneficiaries; or

(c) The use of contracted staff for core services to supplement hospice employees in order to meet the needs of patients due to:

(1) Unanticipated periods of high patient loads;

(2) Staffing shortages due to illness or other short-term temporary situations that interrupt patient care; or

(3) Temporary travel of a patient outside of the hospice provider's service area.

939.23 Non-core services covered under the adult hospice benefit, which shall be provided directly by the hospice provider or under arrangements made by the hospice provider as specified in 42 CFR § 418.100, include the following:

(a) Short-term inpatient care;

(b) DME and medical supplies;

(c) Prescription drugs;

(d) Physical therapy, occupational therapy, and speech-language pathology services;

(e) Home health aide and homemaker services, as described in § 939.20(i); and

(f) Other services specified in the beneficiary's plan of care as reasonable and necessary for the palliation and management of the terminal illness and related conditions and for which payment may otherwise be made under District Medicaid.

939.24 The hospice provider shall ensure that nursing care, physician services, and prescription drugs are routinely available on a twenty-four (24) hour basis, seven (7) days per week. The hospice provider shall also ensure that, when reasonable and necessary to meet the needs of a beneficiary and his/her family or other caregivers, other services covered under the adult hospice benefit shall be made available on a twenty-four (24) hour basis, seven (7) days per week.

939.25 To receive reimbursement for adult hospice services, the hospice provider shall first obtain prior authorization from DHCF or its designee. A separate prior authorization shall be obtained for each election period during which hospice care is to be provided to the beneficiary.

939.26 DHCF shall reimburse for each day that a beneficiary receives adult hospice services at one (1) of the following four (4) prospective per diem reimbursement rates:

(a) Routine Home Care: The base reimbursement category for hospice care representing any of the covered adult hospice services necessary to provide palliative care to a beneficiary while the beneficiary is at home and is not

receiving continuous care as defined in paragraph (b) of this section. Routine home care shall be subject to the following requirements:

(1) Per diem reimbursement for routine home care days shall be made in accordance with Medicare requirements, resulting in a higher per diem rate for the first sixty (60) days of routine home care provided to a beneficiary, followed by a lower per diem rate for all subsequent routine home care days within an episode of hospice care;

(2) The count of routine home care days shall follow the beneficiary, such that if a beneficiary is discharged from one hospice provider and readmitted to another hospice provider within sixty (60) days, the beneficiary's prior routine home care days shall count toward the beneficiary's routine home care days for the receiving hospice provider upon hospice care election;

(3) Routine home care days that occur during the last seven (7) days of a hospice care election ending with a patient discharged due to death are eligible for a service intensity add-on payment; and

(4) The service intensity add-on payment shall be equal to the continuous home care hourly payment rate, as described in paragraph (b) of this section, multiplied by the amount of direct patient care actually provided by a registered nurse and/or social worker, as defined in 42 CFR § 418.114, up to four (4) hours total per day;

(b) Continuous Home Care: The rate category that applies for any of the covered services necessary to maintain a beneficiary at home during a period of crisis, resulting in a per diem rate which shall be divided by twenty-four (24) to yield an hourly rate. Continuous home care shall be subject to the following requirements:

(1) The need for continuous care shall be documented in the clinical record. Continuous care shall not be billed for more than seventy-two (72) hours without prior authorization from DHCF;

(2) Nursing care, provided by either a registered nurse or a licensed practical nurse, shall account for more than half of the period of continuous home care;

(3) Homemaker and home health aide services shall be available, if needed, to supplement the nursing care;

(4) A period of crisis requires between eight (8) and twenty-four (24) hours of care, not necessarily consecutive, per twenty-four (24) hour period; and

(5) The number of hours of continuous care provided during a continuous home care day shall be multiplied by the hourly rate to yield the continuous home care payment for that day;

(c) General Inpatient Hospice Care: The rate category that applies for a beneficiary requiring treatment in an inpatient hospice facility for pain control or management of acute or chronic symptoms which cannot be managed in other settings. General inpatient hospice care shall be subject to the following requirements:

(1) General inpatient hospice care shall only be provided on a short-term basis;

(2) General inpatient hospice care shall be discontinued once the beneficiary's symptoms are under control;

(3) Facilities providing general inpatient hospice care shall meet the requirements described at § 939.20(e); and

(4) Payments to a hospice provider for inpatient hospice care (general and respite) shall be subject to a limitation that the total number of inpatient hospice care days provided to Medicaid beneficiaries in any twelve (12) month period may not exceed twenty (20) percent of the total number of days during that period on which Medicaid beneficiaries have hospice care elections in effect; or

(d) Inpatient Hospice Respite Care: The rate category that applies for inpatient care provided for respite on behalf of a family member or other caregiver for a beneficiary living at home. Inpatient hospice respite care shall be subject to the following requirements:

(1) Inpatient hospice respite care is available for beneficiaries who do not meet the criteria for general inpatient or continuous home care, and whose family members or other caregivers are in need of temporary relief from caring for the beneficiary;

(2) Inpatient hospice respite care shall not exceed five (5) consecutive days and shall be limited to fifteen (15) days per six (6) month period;

(3) Inpatient hospice respite care shall not be available for a beneficiary residing in a nursing facility or ICF/IID; and

(4) Payments to a hospice provider for inpatient hospice care (general and respite) shall be subject to a limitation that the total number of inpatient hospice care days provided to Medicaid beneficiaries in any twelve (12) month period may not exceed twenty (20) percent of the total number of days during that period on which Medicaid beneficiaries have hospice care elections in effect.

939.27 The prospective per diem reimbursement rates for routine home, continuous home, general inpatient, and inpatient respite care shall be in accordance with the annual hospice rates established for Medicare by the Centers for Medicare and Medicaid Services (CMS) and subject to the hospice wage index for the Washington, D.C. Metropolitan Core Based Statistical Area (CBSA).

939.28 The per diem reimbursement rates include payment for the following services performed by the physician serving as the hospice medical director or the physician member of the interdisciplinary team:

(a) General supervisory services; and

(b) Participation in the establishment of plans of care, supervision of care and service delivery, periodic review and updating of plans of care, and establishment of governing policies.

939.29 DHCF shall make a payment for other physician services, in addition to the per diem reimbursement rate, subject to the following requirements:

(a) The services shall be direct patient care services;

(b) The services may not be furnished on a volunteer basis; and

(c) Payment shall be made in accordance with the District Medicaid fee schedule, updated annually and available at www.dc-medicaid.com.

939.30 When a beneficiary who resides in a nursing facility or ICF/IID elects to receive hospice care under the adult hospice benefit, the following shall apply:

(a) The hospice provider and nursing facility or ICF/IID shall enter into a written agreement identifying the parties' responsibilities for patient care, in accordance with 42 CFR § 483.70(o);

(b) On routine home care or continuous home care days, DHCF shall make an additional payment to the hospice provider equal to at least ninety-five (95) percent of the per diem rate for the nursing facility or ICF/IID, to account for the room and board furnished by the facility; and

(c) The hospice provider shall pass through the room and board payment specified at § 939.30(b) to the nursing facility or ICF/IID, in accordance with the terms of the written agreement described at § 939.30(a).

939.31 DHCF shall not reimburse for days of adult hospice services that a beneficiary accrues before the hospice provider obtains physician certification of terminal illness in accordance with the requirements described in §§ 939.7 through 939.9.

939.32 The hospice provider shall demonstrate compliance with the following quality and improvement requirements:

(a) Federal quality of care standards, in accordance with 42 CFR § 418.58; and

(b) Data submission requirements of the Hospice Quality Reporting Program, in accordance with 42 CFR § 418.312.

939.33 The hospice provider shall take the following actions related to quality improvement:

(a) Document the availability of a quality management program plan that meets federal quality of care standards in accordance with 42 CFR § 418.58; and

(b) Appoint a multidisciplinary Quality Management Committee (QMC) that reflects the hospice provider's scope of services.

939.34 The hospice provider shall appoint a multidisciplinary QMC, which shall be responsible for the following:

(a) Develop and implement a comprehensive and ongoing quality management and peer review program that evaluates the quality and appropriateness of patient care provided, including the appropriateness of the level of service received by patients;

(b) Establish and use written criteria as the basis to evaluate the provision of patient care. The written criteria shall be based on accepted standards of care and shall include, at a minimum, systematic reviews of:

(1) Appropriateness of admissions, continued stay, and discharge;

(2) Appropriateness of professional services and level of care provided;

(3) Effectiveness of pain control and symptom relief;

(4) Patient injuries, such as those related to falls, accidents, and restraint use;

(5) Errors in medication administration, procedures, or practices that compromise patient safety;

(6) Infection control practices and surveillance data;

(7) Patient and family complaints and on-call logs;

(8) Inpatient hospitalizations;

(9) Staff adherence to the patient's plans of care; and

(10) Appropriateness of treatment.

939.35 The hospice provider shall submit its Quality Management and Peer Review Program to DHCF or its designee no later than June 30th, annually.

939.99 **Definitions**

When used in this section, the following terms shall have the meanings ascribed:

Beneficiary – An individual who has been determined eligible to receive services under the District Medicaid program.

Counseling services – Services provided by a person who is licensed or authorized to practice as a licensed professional counselor pursuant to the District of Columbia Health Occupations Revisions Act of 1985 (HORA), effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201 *et seq.* (2016 Repl. & 2019 Supp.)).

Episode of hospice care – A hospice election period or series of election periods separated by no more than a sixty (60) day gap.

Homemaker services – Services consisting of general household activities provided by a trained homemaker, when the individual regularly responsible for these activities is unable to manage the home and care for themselves.

Hospice – A public agency or private organization, or a subdivision of either, that is primarily engaged in providing care to terminally ill individuals that meets the licensure requirements set forth in the Health-Care and Community Residence Facility, Hospice and Home-Care Licensure Act of 1983, effective February 24, 1984 (D.C. Law 5-48; D.C. Official Code §§ 44-501 *et seq.* (2012 Repl. & 2019 Supp.)), or in the laws and regulations of the particular jurisdiction in which the facility is located.

Hospice care – A comprehensive set of services described in Section 1861(dd)(1) of the Social Security Act, identified and coordinated by an interdisciplinary

group to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill individual and/or family members, as delineated in a specific, written plan of care.

Hospice medical director – A person who is hired by the hospice provider as a medical director and who is licensed or authorized to practice as a physician pursuant to the HORA.

Occupational therapy services – Services provided by a person who is licensed or authorized to practice as an occupational therapist pursuant to HORA.

Palliative care – Patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facility patient autonomy, access to information, and choice.

Period of crisis – A timeframe during which an individual requires continuous care to achieve palliation and management of acute medical symptoms.

Physical therapy services – Services provided by a person who is licensed or authorized to practice as a physical therapist pursuant to the HORA.

Physician services – Services provided by a person who is licensed or authorized to practice as a physician pursuant to the HORA.

Plan of care – A written document initially developed by at least two (2) members of the beneficiary's hospice interdisciplinary team, one (1) of whom shall be a nurse or physician, describing the scope of services and levels of care to be provided.

Speech-language pathology services – Services provided by a person who is licensed or authorized to practice speech-language pathology pursuant to the HORA.

Terminally ill – An individual with a medical prognosis of life expectancy of six (6) months or less if the illness runs its normal course.